MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, April 25, 2002
10:07 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
BEATRICE S. BRAUN, M.D.
AUTRY O.V. "PETE" DeBUSK
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RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
JANET G. NEWPORT
CAROL RAPHAEL
ALICE ROSENBLATT
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

AGENDA ITEM: Assessing Medicare's benefits
-- Julian Pettengill, Jill Bernstein

MR. PETTENGILL: Good afternoon. The first chapter of this report attempts to set up the report as a whole, addressing widely recognized limitations in Medicare's benefit package, raising the question of why it's important to think about that, what implications it has for beneficiaries access to care and out-of-pocket spending, how beneficiaries attempt to address those consequences, and the degree to which their adopted remedies are effective.

The Congress will ultimately have to decide how to address these problems, and they will have to do so against the backdrop of the longer term problems facing the Medicare program, which are really two-fold. One is the set of well-known demographic changes coming down the road; that is, people like me retiring, and in large numbers. The other is the continuing rapid pace of technological change where we have new things we can do to people. We start by doing new things to a few good candidates and then we spread to doing them for practically everybody, including the old-old. That turns out to be quite expensive.

The demographic problem is primarily a problem of financing the covered population relative to the population as a whole or relative to the working population, who pay taxes to support the program, is mushrooming in size. But the technology problem I think is not entirely a problem of financing. It's also to some degree a question that one should think about a bit in thinking about how or whether to revise the benefit package because that will perhaps -- it's entirely possible that altering the benefit package could affect the degree to which technological change affects spending.

Now for the session this afternoon Jill is going to take you quickly through the logic of the material we present in Chapter 1 and then we'll welcome any comments you have to make about what we need to add or subtract, changes of tone and that sort of thing.

DR. BERNSTEIN: The first chapter of the June report incorporates a lot of material you've seen before in various places and some new material addressing questions about beneficiaries' access to care and financial protection, or recast information.

Rather than spending time on the specifics I'd like to go through the major themes presented in the report fairly quickly so we can spend most of our time listening to you. In particular we need comments on the presentation of the findings about how Medicare's benefit design has or has not succeeded in ensuring beneficiary access to care and financial protection. We want to know what you think is unclear or incomplete or extraneous in the chapter.

We also want to know whether the basic organization and arguments are what you want to say and the way you want to say it, and whether the chapter does what it needs to do to set up the rest of the report.

The first chapter looks at how Medicare's benefit design affects the programs' ability to address two basic goals: ensuring beneficiaries' access to appropriate high quality health care in the most appropriate setting, and ensuring beneficiaries' financial protection. That is, ensuring that financial considerations do not prevent access to care, and the cost of health care do not result in the impoverishment of beneficiaries or their families.

We have a bunch of charts and a bunch of tables in there but I'm going to summarize it in about four sentences. Basically what we want to do is to put those two questions, whether Medicare has reached its goals, in the context of a third implicit consideration which is whether changes in Medicare's benefit package could be made to increase efficiency.

Recognizing that there are limitations available for the program and like any other public program we need to also figure out how we can sort out what the issues are with respect to the benefits package versus issues that get into broader questions of payment policy and budget constraints. This is kind of a thought experiment. Benefits design is only part of the equation about what determines whether Medicare is meeting its goals. We recognize that. Which providers are paid by Medicare, under what circumstances, how much it pays, they're all important. Decisions about coverage and payment policy involve considerations about other budget priorities. We recognize that as well.

But what we want to do here is to focus in particular on the characteristics of the benefits design itself and to determine whether there are problems that, if corrected, could foster more efficient care delivery and better protect beneficiaries. So we know we've set ourselves up to do something that's very difficult to do, but since we can't reassess everything there is to do with the Medicare program we are starting with the benefits package.

The next slide summarizes where we are with respect to assessing financial protection and access to care. I want to do that really quickly again, since we've gone over this in previous sessions. Generally, we conclude after reviewing the evidence on access and financial protection that the glass is about four-fifths full. Medicare has made tremendous differences in beneficiaries' lives, it's provided access to the best in acute care services, it's lengthened the lives of beneficiaries, it's increased the quality of life for many people. Having Medicare is way better than not being insured, and there are a lot of Americans who are really happy when they turn 65.

Some beneficiaries, however, have problems gaining access to and paying for the care they need. The vulnerable populations include the people who are near-poor, older-old, and those with serious chronic illnesses. In addition though, it's important to note that full access and financial protection is, for many beneficiaries, contingent on obtaining some form of supplemental coverage in addition to Medicare. This is because gaps in Medicare coverage leave beneficiaries exposed to some very high costs potentially. These issues are going to be discussed for the rest of this afternoon in the later chapters and I'm not

going to go into the data here unless you want to talk about specifics.

Turning to the issue of efficiency, Medicare's benefit design, the report I think demonstrates, reaps several forms of inefficiency. Cost-sharing; that is, deductibles and insurance are uneven and, in some cases, inconsistent from what would make sense from an insurance perspective and may lead to some undesirable incentives regarding the use of one sort of services versus another, or one setting versus another.

Gaps in coverage for some services, notably prescription drugs but also others, can create serious financial problems for some beneficiaries and may deter people from seeking care or conforming to treatment care that could prevent or delay more serious health care problems down the road. Gaps in coverage also lead beneficiaries to seek out supplemental insurance. This can be confusing, it adds administrative costs, and it encourage the overuse of some services if supplemental coverage shields beneficiaries from costs associated with using medical services that might be unnecessary or of limited value.

Later in the report, as you'll hear, we take a closer look at supplementation and examine what emerging trends imply for beneficiaries' ability to obtain coverage and financial protection in the future. Finally, the report talks about framing the options for addressing some of these problems.

What we want to talk about is how to limit the discussion so that we can focus in particular on whether there are changes in benefits that could lead to better access and better financial protection for about the same amount of resources that are currently being spent.

We do this in two different ways. One is looking at whether there are improvements that can be made in Medicare's benefit design that could be accomplished without increasing Medicare spending. And secondly, as we discussed this morning, we look at whether there are changes that could be made which would improve the beneficiaries' access to care and financial security without increasing total spending on health care for these beneficiaries.

Actually, I want to stop there. We have overheads that show all the charts and figures if there are specific questions you have about them, but in general we just want to go through the framework that we've set out and find out what you think.

MS. ROSENBLATT: My comments span all of the chapters on this issue of the Medicare benefit design and I've got a lot of couple of concerns on the tone. I made a lot of comments about the tone last time. The tone that Medicare supplement plans are the work of the devil continues to come through in this iteration. I think there are comments made that they lead to increased cost for Medicare, that the administrative costs are high, just what Jill just read, gaps create incentives to seek supplementation, which often is complicated, inefficient, or inadequate.

Throughout these chapters we're throwing out words like Medicare supplement plans are complicated, the whole thing is complicated. Well, all of health insurance is complicated. Inefficient, I don't know that that's true. Then, will lead to

higher costs. In one of the chapters, I think in Section F, there's comments that we can't really prove that. So I've just got general tone issues.

Now I do have some questions on the charts that I do want to get to in a minute, but I also, as I was reading through this stuff, had an idea for an analysis. I don't know if there's time to do it, but we keep looking at beneficiaries in Medicare in different categories, whether they have supplemental insurance or provided by the employer or that they bought.

What we're never looking at is what happens to the person that's working, 64-years-old, what are they paying in terms of their contribution? What are they paying in terms of out-of-pocket costs? Then what happens when they pass that magic age 65 barrier and how does it compare?

My guess is that we're going to see -- and I don't know. I haven't done this analysis myself -- that if the costs to that individual are lower because they end up switching from 64 to 65, then that says something about the need for increased cost sharing. I don't think we need to have a decrease when somebody turns 64 to 65.

So I know June is right around the corner and I'm concerned. One of my concerns is I'd like to see us do that analysis. That other overriding concern that I have is, there is a sea change going on as we speak. I mentioned this last week. Employers, we're seeing the third year of increased cost, we're seeing no let up in sight, we're thinking about if the SGR is not changed and physician fees are decreased by 5 percent what is the cost sharing impact going to be on commercial premiums?

All of that is going to lead to new and different things and we're sort of looking backwards. We're saying, how do we restructure the Medicare program -- it was designed back in the '60s; what were insurance plans then? I think as we go through the next few years of increased costs, increased cost sharing to the employees, both their premium share is going to be higher and the cost sharing is going to be higher, and plans are going to be different.

We've got a fee-for-service program. I don't think anywhere in here, unless I missed it, does it talk about maybe we need to design programs that switch care towards more efficient providers. That opens up a whole host of what is a more efficient provider. But I've got a lot of unease about all of this right now.

DR. ROSS: I just want to respond one technical question because I think all the other issues you raised are commissioner issues. You can get data for the 64 versus 65-years-old. We don't easily have that and I'm not sure we could get it usefully done in time for this report. But there are two things that change, one of which is the source of insurance. Presumably for the people who are retiring that year, although most retire at 62, their incomes are also changing considerably. So it's not enough just to look at the cost sharing changing, you'd want to look at other pieces. That's a useful suggestion but not in the next three weeks.

MS. ROSENBLATT: Murray, I would agree with your

modification. All I'm saying is we're just looking at the Medicare population and we're not looking at what is insurance as a percent of income when you're working versus when you're not? Clearly, when you're working you've got expenses like commuting costs, et cetera, that you don't have.

So the point I'm making is, I don't know that anyone has ever done that and to me that would be an interesting thing to do in connection with this.

DR. ROSS: Actually we have done some of that in past MedPAC reports but we haven't got it to the close population. I think we've done working versus Medicare. We haven't done -- am I allowed to call them -- according to the USA Today, older Americans 50 to 64 who are working versus Medicare. I'll see if we have any of that.

MR. FEEZOR: Actually I had some comments that were, with the exception of the Medicare supp market being the devil's playground which I won't try to argue against, that mimics some of Alice's concerns. First, we talked about earlier just generally, I don't know that our presentation presents the gravity of the dilemma that's facing us, nor the opportunities that Medicare as this country's single largest fulcrum, if you will, in health care and health care delivery represents. But that may be something for a later report at a different time. But that's sort of a lost opportunity.

Second, I think I share -- I looked at it a little differently as I went through the materials, that Alice's concerns about we keep looking back and maybe it doesn't give sufficient weight to most recent trends. Maybe we should draw from the actuarial sorority and fraternity and weight most heavily our most recent experience. I think particularly when we talking the materials in this first chapter, which by the way did as good a job I think as anyone could in trying to frame the issues. I should start with that.

But when we talk about, employer generosity is one of the terms used here, without any doubt that's to be said. But as Alice noted I think we're going to look at some, we are looking at some rather fast-paced trends. That is mentioned elsewhere in one of the chapters.

In addition, such things as employer choice of plans. We say that employers do offer choice of plans, yes, but even that -- and it's not just CalPERS. I would offer up a more balanced such as Sears, which has dropped almost in half its choice of plans. Then distinguishing whether that's a choice of plans in terms of vendors or is that a choice of actual benefits.

A couple of other things. I think on Alice's point, and we're looking at Medicare in the absence -- actually I think we're not consistent. I think there are areas there where we talk about -- we do make it relative to the amount of -- I'm trying to remember, somewhere in the chapter that the level of Medicare coverage as a percent of population compared to that of maybe younger people. Yet some other opportunities we do miss, which is maybe, what are the medical expenses as a percent of disposable income might be a helpful reference.

We talk about the percent of Medicare folks who have trouble

getting prescriptions or don't have prescription coverage as being 8 percent or something like that. That's relative to what? So I think just going back and reviewing, are there some general public comparisons that I think I as a public policy maker would want to think about and saying, okay, yes, by itself this looks like we really have a lot of ways to go with Medicare, but compared to what the general population that is provided by employment-based, maybe I need to put that in perspective. We're never going to hit Nirvana in this, so that's the other thing.

Then finally, it might be helpful, just as a footnote, we talk about the number of Medicare eligibles. We assume that -- we probably want to break out a little bit as to why there are some folks who are still not covered by Medicare B and what can or cannot be done by that. There is a measurable population. It is one that has a variety of reasons why, but it's something that I think we probably ought to bring out in perhaps this first chapter.

MS. NEWPORT: Considering the complexity of this I thought you did a very good job in trying to capture everything. I think your two framing options, I think the answer to both of them is maybe. And I think a little bit to that point I would just like to rearticulate, if I can, a frustration with not having more recent data. That's not frustration with you folks at all.

I think it's a problem here. Because I think that although you were very consistent in using 1999 data, at least in most of the discussion, because that's probably the complete data, I think that there were some points where I think the text has to inoculate against I think some significant changes that have taken place in the marketplace since 1999. I think you need to frame that in the text or whatever.

I think the other thing too, I think there are things happening in the Med supp market. I'm not challenging Alice at all on this, but I think that I see dynamics out there that -- I think we should be neutral a little bit on that, or maybe a lot on that. Just, here's the facts. This is what's happened in the market. This is how this will -- again, frame the discussion. I like your use of the word framing.

Part of it too goes to what's happened in the M+C market. What I see as plans exit doesn't -- it may be anecdotal more than factual or data driven, is that I don't see the types of effects that you're articulating here. I think there are greater impacts for those that are financially, in more financial trouble than otherwise. So I think there's some demographic data that I would hope that we could try to take a look at too on the other side of this.

So I think that answering the options is harder than setting out what the state of play is at this point, but I'm very -- again, I wish you had more recent data on a lot of this, and to the extent that you have and can get it from other sources, I think it would be helpful for part of the discussion.

DR. REISCHAUER: I don't think we should go down the road of explaining all the little peculiarities of Medicare like why there are people who aren't in Part B; most of them are actually working elderly. And why some aren't in Part A because of

federal service and things like that. You'll confuse the story.

But I want to engage Alice on supplemental coverage here. I understand why you don't like people to say it's complex, it's inefficient, and it's inequitable but I thought there was a convincing body of information here explaining why. It's not that supplemental policies haven't performed an extremely important function, but the fact of the matter is, we could do it better under a different structure. Certainly you feel that way at Wellpoint. You don't want, in a sense, all of your covered lives to have two or three policies and have to do coordination of benefits and things like this.

Maybe we can use different terms that are less pejorative but I think the evidence is there and that we shouldn't back away from this.

MS. ROSENBLATT: I am concerned about tone. The direction may be appropriate, although I am very worried that our direction is more the way the world has been as opposed to the way the world will be. We're examining options that don't deal with the efficient provider issue, or thinking about Medicare in managed care. We get to it a little bit through the coordination of care but there's a lot of other stuff going on in the marketplace right now that is not touched upon at all. So I'm concerned about that.

Now let me deal with the inefficient. Now there's a comment in -- I'm getting into other chapters, not the one we're one. But there's a comment in here I think about typical admin cost is 20 percent. Admin cost probably ranges from 10 percent to the 35 percent allowed by law. I don't know, with all the functions that a Medicare carrier needs to do that one would say that 10 percent is inefficient. It might look inefficient compared to the admin charge of the Medicare program, but we all know that there are different functions performed, (a). And (b) I think most of us in this room would probably say that not enough admin is being spent on the Medicare program.

But it really is tone. The other tone issue was -- I actually highlighted this one. There was a sentence -- there's a lot of comment about paying for supplemental coverage down to the first dollar of coverage increases costs. As an actuary, I believe that's true. But I don't know that there's definitive proof. We make it sound like something -- let me just -- I'm on page -- I'm sorry. It was the chapter that was in Section F. It was the second stapled one, coverage beyond the fee-for-service benefit package and total spending on care. It's page 12.

Bottom of the page it says, studies have not successfully isolated the extent to which the differences in use of care is due to those with supplemental coverage getting unnecessary care versus those without supplemental coverage going without needed care. That's a nice sentence but in other places throughout these chapters there's this -- it's not said as nicely as that sentence says it. There's this inference that it leads to bad higher utilization.

DR. REISCHAUER: I think that that actually is a function of the way we've set up supplemental insurance and regulated it and it isn't the fault in any way of the entities that provide this

insurance, and the fact that people want that and are willing to pay for it. Whether the increase in cost is good or bad you're saying, Alice, is an open question.

MS. ROSENBLATT: All I'm saying is that the words -- I tried to underline it and I will leave it with staff. There are just areas in the report as it stands right now where the tone is coming through differently than what I think we're saying or trying to say.

DR. NEWHOUSE: I was going to say some of the same things Bob did, but let me say specifically what I thought the facts were that justified the somewhat negative tone. First was the issue that Alice and Bob were just talking about on induced spending. While it's right to say there's no conclusive evidence good or bad and undoubtedly the true state of the world is that it's some of both, the markets insofar as we have one in managed care, for example, has gone away from no cost sharing and care that's free at the point of use. It's even going further away from it and there's, if anything, more control in that setting than in the traditional Medicare world.

So I think Alice as I heard her just then doesn't disagree that there's increased spending. The issue is whether the increased spending is good or bad. And I say it was probably right to take a view that, particularly for vulnerable subgroups, some of the increases are good. But once we have set -- first of all, part of that group is covered by Medicaid so then cost sharing does not become an issue. Let me stop on induced --

The other thing on the loadings, I think it probably has to be right that individual marketing on the Medigap side raises administrative costs above having it in the Medicare program. If most people buy it or get it in some way, shape, or form, as is the case with the back end coverage at least, then it clearly seems better to bundle it with the underlying Medicare program, which is basically how I read the chapter now. So I was actually pleased with the generally negative tone about Med supp.

DR. NELSON: Joe took it further than I would have. I paid close attention to what Alice said at the last meeting so I read this with an idea of trying to measure tone in my own view and I thought it was quite neutral. I didn't think that it came across particularly negative. As a matter of fact, if the tone were altered in a way that it made it look like we were coming out making a pitch for supplemental insurance I'd have a big problem.

MR. SMITH: Alan, Joe, and Bob have said a lot of what I wanted to say but I really did think that the tone here was pretty flat. Let me just read two sentences from the pages that Alice referenced. Multiple sources of coverage also increase administrative expenses. It doesn't say it's wasteful. Doesn't say they're thieves. It simply states a fact which we can find easily in the literature. And on the page before it states that Medicare beneficiaries with supplemental coverage cost the Medicare program more than those without such coverage. There's not a normative word in that sentence.

I want to be careful not to confuse tone with facts that we don't like. I thought the chapter did quite a good job of assessing and presenting what we know. The implications of that

may be troubling but I don't think the tone in which it's presented is troubling.

The other point I wanted to make, just come back to Bob's comments earlier today and Alan's, I think this is terrific stuff and very well done, but it doesn't start on page 1. There needs to be a context setting chapter I think, Murray, which establishes that we're looking down a set of boxes of the health care system, the health care system as it applies to Medicare beneficiaries, and at Medicare. And that the interaction between Medicare and the balance of the system that affects its beneficiaries and the other two-thirds of the health care system, that those interactions are important. They're important for policy reasons and they're important to Medicare beneficiaries.

Part of what we're trying to do here is have the Medicare conversation in that broader context. I think it's very important to say that early before we get into the more Medicare-specific stuff even in the introductory chapter.

MS. NEWPORT: I guess David hit it fairly accurately, I think. My view of this is that as Medicare fee-for-service coverage and technology and everything else that you've articulated has changed, the markets have been created for extra services, extra coverage, extra -- you know, covering deductibles and copays as those have increased. This has driven new entry and interest in new entry into -- TEFRA originally with the old risk program and cost payments to M+C, the whole plethora of things, options that are out there in terms of filling the gaps that Medicare could not fill financially. So it was a build upon, layered effect.

Now as costs have increased, those markets and response in the markets have changed, as have employers ability to respond to that, as have retirees demand to respond to that. None of that which is intrinsically bad. It's just that as a policy in this country do we want to cover all of that? Then of course that puts pay to the whole description of, can we do this without increasing total health care spending? No, we can't.

So I think that to the extent that technology has moved us to consider broader coverage or different types of coverage, it's still more costly. So how do you create an environment where you have options for folks? But again, we may never get to the point where we have to have a perfect or can have a perfect world in terms of what is out there and is it affordable for the greatest number of people. I guess without cost sharing and having people, soon to be me, recognize that I may have a bigger financial obligation than I thought when my parents entered Medicare, we're just getting into areas that we have to decide what the scope of this is going to be.

I just think we have to be, as you've attempted to do, be prudent in recognizing the challenges out there in terms of what this will cost. Yes, there may be inefficiencies in the system. I don't care where they are. I'm not sure that we can redirect this in a way that doesn't come up against what are we going to be asking people to pay that we haven't asked them to pay before?

So again, understanding what's happened in Medicare and what it means for folks, and what is, from a public policy decision,

Congress or whoever needs to decide what to do. This is kind of where we're going. I think we should try to be as neutral as possible in all of this but I'm not sure that we can really, in good faith, make any kind of recommendation that this is not going to somehow increase total health care spending in terms of out-of-pocket exposure that people are going to face in the future.

MR. HACKBARTH: Can I just leap in for a second? I keep pushing myself to the bottom of the queue and can't resist jumping in.

Alice, I've thought a lot about the points that you made at the last meeting and I'm attracted to them, in part just because my personal philosophical orientation, all other things being equal, I like private involvement, private solutions to problems, if you will. But when I look at the supplemental market I find it difficult to find a lot of the things that I like about private involvement and I find some things that I don't like.

What I often like about private solutions is decentralized decisionmaking, not being involved in administered pricing systems, such as we engage in here so often, opportunities for innovation and clinical program design that we might find in some of the best M+C plans and the like. Yet that's not the sort of activity that supplemental plans are involved in, by their very nature. They're not changing the basic pricing mechanisms. They're not creating opportunities for clinical innovation program development. I just don't see it there.

I do see some confusion, complexity added to the system which I don't think of as a plus.

One other potential advantage of private supplementation as opposed to public expansion of benefits is that it has a very different financing implication. Part of the challenge that we have on the public side, if we have public expansion, is the intergenerational transfer involved. Right now we have a demographic situation where a smaller and smaller number of workers are going to be financing care for a growing number of retired people, and that's a very real problem.

To the extent that we have private supplementation as opposed to taxpayer-financed supplementation we may reduce the intergenerational transfer which, arguably, might be a good thing. But even there you might say, let's have optional supplementation with less intergenerational transfer but do it through a mechanism that is cleaner, more efficient, than the existing Medigap supplemental market. Now you could have options under Medicare that people would pay for out of their own pocket, no intergenerational transfer involved, that could be much more efficient than the supplemental market that currently exists.

If we're worried about the availability for low income people and their ability to buy that supplemental you could have income-related subsidies that would make it available to lower income seniors. So you'd have reduced intergenerational transfer, which is a plus of supplementation as opposed to putting it into basic benefits, without a lot of the minuses. I'll leave it at that.

MS. ROSENBLATT: May I respond?

MR. HACKBARTH: Sure.

MS. ROSENBLATT: I think you spoke much more eloquently than I can and I agree with a lot of what you said. I think you might be helping me articulate my problem by what you just said. I too like a private solution. I don't necessarily think that the existing Med supp market is a good one. But I think one of the biggest problems with it is that law set in 1992 what the benefits needed to be.

You mentioned the opportunity for innovation. When you've got a set of 10 standard plans there's no opportunity for innovation. I don't know of any benefit plan we have at Wellpoint that hasn't changed ever in the last 10 years. That would be unthinkable. We're changing our plans every year, sometimes more often than once a year, as we're understanding what's going on in the marketplace, what consumers want, what employers want. So I think that we've created something that can be undone.

The tone that I'm worried about is that we're taking shots at what's there, maybe appropriately, without focusing on there are ways to change it. We could change this private market by allowing innovation, by allowing -- we've got a fee-for-service program and maybe we could, through the supplement market, allow some of the -- maybe the care coordination could occur through the supplemental benefits. There's just a lot of stuff like that that I think we've left out.

Now on the other side of all that is what led to the legislation to start with. We talked about that last session too. It will be very complex, but the financing issue cannot be ignored.

DR. REISCHAUER: Just on this point, we do have Medicare+Choice and it has a private fee-for-service option. It has a PPO option. It has HMOs, coordinated care. It's the whole enchilada as opposed to just a little filling on top of Medicare fee-for-service. So the opportunity is there. We might not pay it right but that's a whole different series of questions.

MS. ROSENBLATT: That's exactly what I'm talking about because I agree with you, but not paying it right is destroying that as well as an option. You can't look at that and say, where's the innovation when you've got a bigger problem with the way it's being paid.

MR. FEEZOR: Three more pedestrian issues. One, in this particular chapter and a couple that followed I felt that a couple of the charts, while they were excellent, were almost too laborious to -- you almost had to work at them to understand the real meaning. If that's appropriate to Washington, fine. Otherwise we might look at simplifying how those charts project. I had to say, what does this really mean? So observation one may speak more to my inabilities than it does anything else.

Second, I think we have to be very, very careful and I found this in a lot of the employer surveys that I've looked at, we've got to be very clear that when we talk about retiree coverage we know whether it's pre or post-65. That's a big issue and in some of the employment surveys that I've seen don't make a good distinction of that. I may offer your early retiree coverage up

to 65. I may not offer anything after that.

Even more important, back to more current trends, whether I may offer my existing workforce or my existing union-negotiated contracts some retiree coverage, I may not be doing it for any of my new hires. So I'd just make sure when we speak to that that we make -- there may be some small distinctions.

Then the final thing, I can't remember whether it was in this chapter or one of the subsequents when we talk about the aggregate expenditures in the Medicare supp area as being $450-some billion or whatever it was in Medicare and Medicare supplemental. Just curious on that whether that was -- does that include tax expenditures or was that simply cash outlays?

DR. ZABINSKI: Total spending outlays is everything spent by all sources.

MR. PETTENGILL: By all sources.

MR. FEEZOR: Would not be tax treatments that were given to premiums and so forth.

DR. ZABINSKI: No, it does not include tax treatment.

MR. PETTENGILL: No, it's actual spending.

MR. MULLER: I think these chapters have evolved quite well over the course of the last few months. Maybe we're beating ourselves up too much. I think especially a major contribution that's been made as it evolves is this relationship between the public spending and the total spending, and the interplay between private and public. I think when one thinks about -- I mentioned this to Glenn at lunch, when one thinks about at least some of the conventional ways this issue is being discussed just six, eight months ago, which drug benefit plan do you prefer, and to try to put this now into the bigger context, especially interplay.

For example, one of the more frightening statistics in here in the sense of what one thinks about the consequence of public spending is the dramatic decrease in retiree coverage. Now playing that out, if that continues as it has over the last few years, can have a very substantial impact on the Medicare program costs independent of any judgment made by the people who run it. So in some sense those private judgments being played out, as they no longer cover the retirees in the same way, can have a very big effect on the program costs, perhaps beyond some other judgments that people think are in front of us right now.

So I think continuing especially in that -- whether it was David or somebody else who asked for that kind of cover chapter, I think trying to stress in that overview chapter, or at least the overview paragraphs, the fact that we are paying a lot of attention in these subsequent chapters to the interplay between the private coverage of costs for the elderly, or the over 65, versus total costs and the interrelationship between the two. We mentioned last month the stresses that the states are under now they may start changing some of their coverages as well in terms of supplemental and so forth.

So I think understanding that interplay I think is a major contribution. I think these chapters have done a very good job of it, and I think pointing out the extent to which these chapters deal with that issue is a very useful thing to put right

into the beginning.

DR. BRAUN: I think it's important to remember that there are a tremendous number of changes that could be made to Medicare to make it make it more sense, the cost sharing and so forth, without adding any expense to the program. Certainly if we add benefits, particularly the drug benefit, that's going to require more money. But Medicare really could have a lot of changes, and that would impact on the supplemental and the type of supplemental coverage or whether or not anybody would carry supplemental coverage.

But I think we should remember that we could change the program tremendously without any extra cost, although we do need drug coverage and we do need that extra cost.

DR. REISCHAUER: Could you just run down a list of those things? Are you holding them in the secret vault at AARP?

[Laughter.]

DR. BRAUN: No, but I think the cost sharing could be changed a good bit and the deductible situation could be changed a good bit.

DR. REISCHAUER: You mean raise some and lower others?

DR. BRAUN: Yes, right.

DR. REISCHAUER: So you're compensating --

DR. BRAUN: -- and come out even in the end. Catastrophic and drug costs I think we need to do something about, and they may add extra money. But other things I think could be shifted around without cost.

MS. RAPHAEL: I just had two things that I thought needed to be amplified a bit. One of the principles that was interesting was this notion that you should have higher cost sharing when something is non-discretionary than when it is discretionary. But one of the questions I had was whether or not we know to what degree some of the services in fact are discretionary.

For example, going into a nursing home, to what degree is that something that's discretionary? We say that generally you don't enter a hospital unless you have to. But I was very interested in that whole area and what we know about patterns of utilization.

Then the other thing I was struck by in reading this that I don't think I had given enough thought to was that the Medicare population really values predictability and they're willing to pay a lot for predictability. As we think about restructuring options I think we need to keep that value in mind.

DR. BRAUN: I think that's really important because we do have to remember that the older population can't go back to work again and get back their assets or build up assets again if they once lose them through programs. So that predictability is explainable and I think is a very high value for older people.

MR. HACKBARTH: We've used our allotted time for this.

MR. PETTENGILL: But you didn't fix it.

[Laughter.]

MR. HACKBARTH: Is there anything specific that you would have liked us to address that we didn't? Very specific.

MR. PETTENGILL: The way these things work is we puzzle about what you said. Sometimes we aren't quite clear what it

meant, other times there's a conflict in what various people said and we have to figure out which of them we should go with. But primarily the way this works is we will take all of what you said back with us and we will try to figure out how to write some kind of an overview that sets the backdrop for the report as a whole and says, we're really not ignorant of all these other larger issues that are playing around in outer space. We will send it to you, and you will read it, and then you will get back to us and say, you either caught what we meant or you didn't.

MR. HACKBARTH: On that note we will move on. Thank you.